

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012497	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/02/2014
NAME OF PROVIDER OR SUPPLIER LAMPLIGHT INN AT THE LELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00138315 completed on 12-3-13.</p> <p>Complaint IN00138315 -- Corrected.</p> <p>Survey date: January 2, 2014</p> <p>Facility number: 012497 Provider number: 012497 AIM number: N/A</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: Residential: 79 Total: 79</p> <p>Census Payor type: Other: 79 Total: 79</p> <p>Sample: 3</p> <p>Lamplight Inn at the Leland was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00138315.</p> <p>Quality review completed on January 3, 2014 by Randy Fry RN.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE